King County

VETERANS AND HUMAN SERVICES LEVY
2008 STRATEGY AREA ANNUAL REPORTS

Strategy 4.2
Pilot New Services for Maternal Depression

OBJECTIVE

The Levy's fourth strategy helps families at risk with a set of programs designed to strengthen the bonds between parents and children and to help parents become self-sufficient. Many families have a difficult time getting off to the right start: teen parents, immigrants, and parents who have been homeless or incarcerated or have experienced domestic violence often need help learning to care for their children and build a stable life. This kind of help – in the early months and years after a child is born – can prevent child abuse and neglect, while giving children and their families a healthy start on life. The goal of Strategy 4.2 is to support maternal-child attachment and maternal health by piloting new services for maternal depression.

Depression – one of the most prevalent and disabling mental illnesses in the U.S. – is twice as likely to affect women as men, with rates of major depression peaking during women's childbearing years. Research has demonstrated that maternal depression can affect parenting behaviors and, ultimately, harm children's health and development. The Veterans & Human Services Levy Service Improvement Plan (SIP) suggests piloting initial investments to address maternal depression in five or more sites, to be integrated and coordinated with the Levy investment in integrated behavioral health services in safety net primary care.

POPULATION FOCUS

The target population for this strategy includes:

- Young first-time mothers
- Recent immigrant mothers who are isolated from services and face linguistic and/or cultural barriers to participation in community life
- Low income pregnant and parenting mothers in King County.

PROGRAM DESCRIPTION

Participating agencies will provide:

- Education about depression and other mood disorders
- Interpersonal support to strengthen women's social support networks
- Mental health screening using standardized clinical tools
- Mental health and chemical dependency services in safety net primary care settings and referral to mental health and chemical dependency providers where indicated.

The service delivery model used in integrated mental health services is the collaborative stepped care model, also known as the IMPACT Model. The stepped care model is an evidence- and outcomes-based practice model that applies key concepts of the chronic care model to treat common mental disorders in a primary care setting. Collaborative stepped care has been shown to improve access, reduce overall costs, and improve mental health outcomes. The IMPACT model is listed on the National Registry of Evidence-based Programs and Practices (NREPP) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

PROGRESS DURING 2008

Funds for this strategy were awarded via a Request for Proposal (RFP) process in February 2008, with awards finalized in April. As a result of the RFP, providers in nine clinics and maternity support programs are piloting interventions to support pregnant and parenting low-income mothers and their children aged 0-12. Providers include the following:

- **HealthPoint** focuses pilot services in its Auburn and Federal Way clinics, serving women and children from throughout South King County. HealthPoint's pilot efforts for mothers and children enhance a well established behavioral health program.

- **Country Doctor Community Health Centers** builds upon its successful maternity support and behavioral health programs, offering enhanced services for mothers and children at its Carolyn Downs and Country Doctor locations. Peer support groups are offered in Spanish and English.

- **International Community Health Services'** Holly Park and International District clinics provide culturally appropriate, in-language services to Asian American, Native Hawaiian and other Pacific Islander mothers and children. In addition to peer support groups for mothers, ICHS also offers groups and classes to support fathers.

- **Neighborcare Health (formerly Puget Sound Neighborhood Health Centers)** serves its diverse maternal and pediatric populations at the 45th Street Clinic. Funds support the addition of a bilingual, bicultural community health worker to the maternity support program, serving as a cultural bridge for Neighborcare's Latina clients.

- **Sea Mar Community Health Centers** is piloting a Comadre (literally, "co-mother") facilitation and treatment model, to assist women to engage in peer support and mental health services. New services are being offered initially at the Burien clinic, and will be expanded to additional sites. Many in Sea Mar's Latina, Spanish-speaking population are recent immigrants, who are at increased risk for depression.

- **Valley Cities Counseling and Consultation** and the **University of Washington Department of Psychiatry** support primary care providers in all clinics. Staff provide psychiatric consultation on both adults and children served in the pilot programs. Psychiatric consultation services are funded by the Children's Health Initiative.

- **UW Harborview Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (**CHAMMP**)** provides project evaluation.

Due to difficulties in hiring, most sites did not begin providing services until September, 2008.

Annual awards are as follows:

Agency	Veteran Services Funds	Human Services Funds	Total Levy Funds Awarded
HealthPoint		$109,045	$109,045
International Community Health Services		$113,000	$113,000
Neighborcare Health		$73,905	$73,905
Sea Mar Community Health Centers		$73,000	$73,000
Country Doctor Community Health Centers		$113,000	$113,000
Total		$481,950	$481,950

SERVICES PROVIDED

Number Served. A total of 2,900 persons were served; 79% resided in South King County.

Total Served	East	North	Seattle	South
2,900			618	2,282

Living Situation. Approximately 4% of those served were homeless; while a small number in percentage terms, it represents 116 individuals.

Living Situation		
Homeless	116	4.0%
Not Homeless	2,284	96.0%

Age Group. Participants in the program were divided between children from 0-12 (1,371, or nearly half of those served) and their mothers.

Age Group		
0 to 5	1367	47.1%
6 to 10	4	<1%
11 to 13		
14 to17	71	2.4%
18 to 34	814	28.1%
35 to 59	297	10.2%
60 to 74		
75 to 84		
85 and over		
Unknown	347	12.0%

Gender. Those served by the program were primarily young women and their babies.

Gender		
Male	743	27.1%
Female	1998	72.9%

Race. The majority served by the program were Hispanic/Latino, followed by White/Caucasian and Asian and Asian-American women.

Race		
American Indian or Alaska Native	19	1.0%
Asian, Asian-American	490	16.9%
Black, African-America, Other	258	8.9%
Hawaiian Native or Pacific Islander	111	3.8%
Hispanic, Latino	1200	41.4%
Multi-Racial	66	2.3%
White or Caucasian	713	24.6%
Other/Unknown	43	1.5%

Veteran Status. The project did not serve any veterans.

Outcomes. A total of 1,414 pregnant and parenting mothers were screened for depression. Of these, 234 clients were identified as having depression, mental health, or substance abuse issues through screening; 20 clients attended peer support groups or received other early interventions during pregnancy or early parenting years; and 37 clients received treatment and follow up through integrated behavioral health programs.

Reporting on the results of periodic screening were delayed for three months as the adaptation of UW's Mental Health Integrated Tracking System (MHITS) did not launch for mothers and children until the middle of November 2008. The MHITS, a web-based mental health registry, is shared across all clinics and consulting psychiatrists, allowing for tracking of clinic services, referral activities, consultation, and screening outcomes. The MHITS will be used by clinics to track women and children with positive screens or other mental health concerns, and to track outcomes of those who have been successfully engaged in treatment.

As noted, a total of 1,414 pregnant and parenting women were screened for mental health concerns in the last eight months of 2008. Of this total, 234 (17 percent) screened positive for depression. Interventions for 190 women engaged in follow-up services included comprehensive clinical assessment, social work and counseling visits, and participation in facilitated peer support groups. Fourteen women have been receiving interventions and support for ten or more weeks and of those 14, one woman (7 percent) has shown 50 percent or greater improvement in mental health function, as measured by standardized depression screening tools. Currently, a database programming error is significantly under-representing improvements in depression screening scores; this error will be corrected in March 2009. Staffing challenges have caused implementation delays at four of five organizations in 2008, but all are now fully staffed.

Providers in eight clinics and maternity support programs at HealthPoint, Country Doctor Community Health Centers, International Community Health Services, Neighborcare Health, and Sea Mar Community Health Centers are piloting interventions to better support pregnant and parenting low-income mothers and their children aged 0-12 years.

In collaboration with the University of Washington, clinics implemented a web-based registry, the Mental Health Integrated Tracking System, (MHITS) to track families served in this pilot in early November. MHITS is a key tool to evaluating the outcomes of this pilot program.

Also in early November, Public Health – Seattle & King County and the University of Washington co-sponsored a two-day training for all social workers and other community health staff involved in this pilot project and in other behavioral health programs funded through the Veterans and Human Services Levy. Training for this pilot was provided primarily by faculty from the University

of Washington Department of Psychiatry, Department of Social Work and Children's Medical Center.

All of the clinics implemented their screening protocols for mothers and children by the end of 2008. Training support has been a need at most agencies. Public Health has trained staff at several agencies and can provide training upon request.

For children 0-5 years, clinics are assessing child progress toward developmental milestones at the well child check, and developmental "red flags" are serving as a trigger for further mental health screening and assessment. For children 6-12 years, mental health screening is conducted at well child checks.

Public Health staff trained community health staff on appropriate screening tools starting in October. Staff members have also been meeting regularly with support group facilitators and developed an eight session support group curriculum to guide group development.

SUCCESS STORY

Country Doctor served a young mother who had recently emigrated to the U.S. from Mexico and was very isolated. She was screened with the PHQ-9 and described several symptoms of depression. She had recently given birth and was under a lot of stress in her home.

She accepted the social worker's invitation to participate in their support group for Spanish speaking mothers, and attended all eight sessions. The sessions contained a mix of education regarding parenting skills, psycho-education about depression, and stress management and self-care skills. By the end of the eighth week, this client had bonded with the other women in the group, learned how to ride the bus and go to the library, and had developed essential knowledge about child development. She told the group leaders how much the group had changed her life and made her feel much more capable as a parent and as a person.

FOR MORE INFORMATION

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